Testimony on LB1093
Before the Health and Human Services Committee
Nebraska Legislature

Dianne DeLair, JD
Senior Attorney
Disability Rights Nebraska

Good afternoon,

My name is Dianne DeLair, spelled D-I-A-N-N-E D-E-L-A-I-R, and I am the Senior Staff Attorney at Disability Rights Nebraska. I am here today to testify in support of LB1093.

As part of its monitoring activities, Disability Rights Nebraska has become intimately familiar with numerous privately-owned assisted-living facilities and mental health centers across the state where residents' primary disability is severe and persistent mental illness. These facilities are often hidden from the public in rural communities across Nebraska or in larger cities, with the public unaware of the conditions that persist for the residents who are forced from one location to the next. These facilities are all over our state and what links them together is not the services they provide; rather, it is the deplorable conditions, the neglect and abuse that takes place, and the congregation and isolation the likes of which most of us cannot imagine. As one former resident of Hotel Pawnee Assisted Living Facility said, "I felt like a rat trapped in a cage. It's degrading to your spirit to live there."

On September 3, 2017, a United States Army Veteran was found deceased at the Life Quest assisted living facility in Palmer, NE. The circumstances of her death are tragic. Months earlier Nebraska Department of Health and Human Services conducted a four-day inspection in June of 2017, followed by a five-day inspection in July of 2017. The report was completed on July 21, 2017. In a random survey of residents, the U.S. Veteran, identified as "Client 7," was part of the sample. The findings contained in the July 21, 2017 report were alarming:

> No evidence she received services specific to her mental health needs. Interview with Client 7 found she was an insulin dependent diabetic, diagnosed with stomach ulcers, throws up and has diarrhea daily. Facility failed to ensure clients with identified therapeutic mental health needs had access to routine and ongoing mental health services and failed to complete current client need assessments for 10 of 10 sampled clients, including Client 7. This affected 10 of 10 sampled clients and 2 additional clients. The violations of the facility involving the treatment and care for Client 7 keep going.

When the observations of the facility were made during the on-site investigations, why did the State fail to act? When the investigative report, dated July 21, 2017, identified the systemic failures, why did the state fail to take action?

These are the questions that must be answered. Another question, why are individuals with severe and persistent mental illness living in isolated, segregated, and congregated conditions in our State? Why do tax dollars flow to keep the doors of these mini-institutions open? The State of Nebraska relies on the existence of these types of facilities because the services, supports, and needs of a very vulnerable population are not being met.

Instead, people are shuffled from one facility to the next. In fact, individuals who were forced to move out of the Life Quest facility in Palmer, NE were placed at the Life Quest facility in Blue Hill, NE. But not before the Division of Public Health issued a Notice of Disciplinary Action against this mental health center in a 42-page report, placing the facility on probation and assessing a $10,000.00 fine. Well guess what, this facility will be closing its doors on February 26, 2018. Residents and guardians scramble to find new places to live. HHS, aware of the systemic failures of this facility, dating back from 2012, again has failed to act.

This is not only about abuse and neglect, but a right to live in integrated settings. The Department's ongoing failure to act continues to place the lives on Nebraska's most vulnerable citizens at risk. The Department's reliance on facilities like Life Quest violates Title II of the Americans with Disabilities Act as interpreted by the U.S. Supreme Court in *Olmstead v. L.C.* Although the Department has a legislative mandate to develop an *Olmstead* plan, and efforts have been made to develop a plan, no actual change has happened. A "plan to plan" is not an *Olmstead* plan and the State remains vulnerable until it does something to protect people like the residents of Life Quest and the numerous other facilities serving this population. That can be done only by developing systems, supports, and services that allow individuals with mental health conditions to live free from the congregation, isolation, and danger of facilities like this. The urgency is apparent and the Department has no more excuses and must act now.

The U.S. Department of Justice has been involved in numerous *Olmstead* enforcement actions involving private facilities. For example, after a lengthy investigation of North Carolina's mental health service system, the Department issued a findings letter in July of 2011 concluding that the State violated Title II by administering its behavioral health system in a manner that unnecessarily segregated persons with mental illness in large, privately-owned adult care homes. The Department entered into a settlement agreement with North Carolina on August 23, 2012. In addition to other provisions contained in the settlement agreement from August 23, 2012, the agreement expands

access to community-based supported housing. Supported housing provides integrated housing that promotes inclusion and independence, and enables individuals with mental illness to participate fully in community life.

The State of Nebraska must make this extremely vulnerable population a priority and must act now. The Inspector General of Public Health can provide the oversight that The Nebraska Department of Health and Human Services cannot.